PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)**
☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Linezolid (generic Zyvox®)

Member

Last Name: ______________________ First Name: ______________________
ID #: ______________________ DOB: ____________ Gender: ____________
Primary Care Physician: ______________________

Requesting Physician: ______________________ Phys. Phone: ____________ Phys. Fax: ____________
Physician Address: ______________________
Physician NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ____________

☐ Prescriber is an infectious disease specialist
☐ Prescriber has consulted with an infectious disease specialist

Product and Billing Information

Drug product:
- ☐ Linezolid 600 mg tablet
- ☐ Linezolid 100 mg/5 mL oral suspension
- ☐ Linezolid 600 mg/300 mL injection
- ☐ Zyvox 200 mg/100 mL injection

Start date (or date of next dose): ____________
Date of last dose (if applicable): ____________
Dosing frequency: ____________

Place of administration:
- ☐ Self-administered
- ☐ Physician's office
- ☐ Outpatient infusion
  Facility: ____________ NPI:____________ Fax:____________
- ☐ Home infusion
  Facility: ____________ NPI:____________ Fax:____________

Billing:
- ☐ Patient to fill at community pharmacy
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy:____________ NPI:____________ Fax:____________

ICD code(s): ______________________

Additional information

Note: If approved, authorization is for a maximum of 14 days. Authorization may be extended an additional 14 days if treating vancomycin-resistant *Enterococcus faecium* infection. Longer courses of therapy may be approved if recommended by an infectious disease specialist.

Review of precertification requests for indications and/or duration of therapy in the below criteria will be reviewed by a clinical pharmacist and/or medical director.

Precertification Requirements

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 02/2018
Last reviewed 11/2017

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient has one of the following conditions:
   a. Invasive vancomycin-resistant *enterococci* (VRE) infection
   b. Documented methicillin-resistant *Staphylococcus aureus* (MRSA) or other gram-positive bacterial infection including: Pneumonia, complicated skin/skin structure infection including diabetic foot infections without osteomyelitis, and uncomplicated skin/skin structure infections.
2. Culture and sensitivity completed and faxed to Priority Health
3. Documented failure, contraindication, or allergy to all other susceptible oral antibiotics
4. Not using a medication that is contraindicated with linezolid (if provider is choosing to use in combination, please provide documentation that provider is aware of interaction)

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?
☐ Invasive vancomycin-resistant *enterococci (VRE)* infection
☐ MRSA infection, list diagnosis: ______
☐ Other gram-positive bacterial infection, list bacteria & diagnosis: ______
☐ Other – the patient's condition is: ______
Rationale for use: ______

B. Was a culture completed? ☐ Yes ☐ No

C. Was antibiotic susceptibility determined?
☐ Yes (fax results with this request) Note: results must show infection is not susceptible to alternative antibiotics
☐ No – rationale for use: ______

D. What antibiotics were previously used that were not successful in treating the patient's current infection?
☐ Antibiotics used include:
Drug: ______ Date: ______ Outcome: ______
Drug: ______ Date: ______ Outcome: ______
Drug: ______ Date: ______ Outcome: ______
☐ No other antibiotics have been used for the patient's current infection

E. Does the patient have an allergy or contraindication to alternative antibiotic therapies?
☐ No
☐ Yes:
Drug: ______ Reaction: ______
Drug: ______ Reaction: ______
Drug: ______ Reaction: ______

F. Is the patient taking any medications that interact with or are contraindicated when used with linezolid?
(examples: dopamine, bupropion, buspirone, MAOI (Nardil, tranylcypromine, Marplan), meperidine, SNRI (venlafaxine, duloxetine, Pristiq), SSRI (fluoxetine, paroxetine, citalopram, sertraline, escitalopram), pseudoephedrine, phenylephrine, tricyclic antidepressants (doxepin, amitriptyline, clomipramine, nortriptyline), triptans (sumatriptan, naratriptan, frovatriptan, rizatriptan, eletriptan, zolmitriptan)

☐ Yes, list medication and document if provider is aware of interaction:
______
☐ No

G. Provide any additional information you feel is necessary for review of this request: ______
______
______

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Last reviewed 11/2017